North West **LHIN**

Creating Healthy Change

2012 - 2013 Annual Report

Ontario
Local Health Integration Network

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Message from Chair and CEO

It is with great pride that we deliver the 2012-2013 Annual Report for the North West Local Health Integration Network (LHIN). This document looks back over a year of collaboration and partnership with the health service providers of Northwestern Ontario, detailing the North West LHIN's activities and accomplishments as we work to build a better and more sustainable health care system for the people of this region.

At the North West LHIN, we understand that, in every year, there are challenges to be overcome and opportunities to be seized. Health care spending is rising too quickly to be sustainable, and we have an aging population that will make increasing demands on our health care system in the years to come. The challenges are not new, but they become more obvious with every year that passes.

This past year marked the final year of the 2010-2013 Integrated Health Services Plan (IHSP II) and the development and launch of the 2013-2016 Integrated Health Services Plan (IHSP III). In addition, 2012-2013 was the first full year for the implementation of the Health Services Blueprint, our 10-year plan to reshape, transform, strengthen and sustain the health care system in Northwestern Ontario. The Health Services Blueprint contains 44 recommendations, including a plan to bring providers together under a framework in which care services will be organized and delivered at three levels within the North West LHIN: local, district, and regional or LHIN-wide.

If there was a broad accomplishment in 2012-2013 of which we are most proud, it would have to be the ongoing work being done to enhance and increase the community-based health services offered in Northwestern Ontario. From long-term care to mental health and addictions services to chronic disease prevention and management, the North West LHIN worked hard to improve the supports offered to patients, clients, and their families in their homes and communities, providing the right care at the right time in the right place. Programs like Home First have been a resounding success, and Alternate Level of Care days – days patients spend in hospital when they would be better off receiving care in a different setting – were reduced once again. All as a result of providers working together: a sign of a health care system moving in the right direction.

As always, we would like to acknowledge and thank our health service providers for their ongoing commitment to patients, clients and their families, and for the support they have given the North West LHIN as we continue to work together to transform the system. We would like to thank the members of the North West LHIN's Board of Directors for their vision, leadership and dedication to health care in Northwestern Ontario. In addition, we would like to thank North West LHIN staff members for their diligence and hard work, day in and day out, over the past year.

Joy Warkentin
Chair

Laura Kokocinski
CEO

Board of Directors

The North West LHIN is governed by a government-appointed, skills-based Board of Directors, accountable – through the Chair – to the Minister of Health and Long-Term Care for the LHIN's use of public funds, for achieving results through execution of its strategic directions and for the performance of the local health system. The Directors are appointed by Order-in-Council for a term of one to three years, subject to a six-year maximum.

The North West LHIN Board of Directors has adopted a policy governance model with a focus on:

- Addressing population health;
- Improving the patient experience; and,
- Ensuring good value for money.

OUR STRATEGIC DIRECTIONS

The North West LHIN is guided by the strategic plan created by its Board of Directors, which establishes a common vision and common directions for the LHIN and for the region's health service providers.

The four strategic directions outlined in the North West LHIN Board of Directors' Strategic Plan, *2010-2013 Leading Health System Transformation in Our Communities*, are as follows:

1. Improved health outcomes resulting in healthier people;
2. Access to health care that people need, as close to home as possible;
3. Continuous quality improvement; and
4. Well-managed resources.

MEMBERS OF THE BOARD

Joy Warkentin
Chair
Thunder Bay
Term: Jan. 27, 2013
to Jan. 26, 2016

Anne Krassilowsky
Vice Chair
Dryden
Term: May 17, 2011
to May 16, 2014

Reg Jones
Secretary
Thunder Bay
Term: April 18, 2011
to April 17, 2014

Dennis Gushulak
Ear Falls
Term: July 28 , 2010
to July 27, 2013

Dan Levesque
Geraldton
Term: April 18, 2011
to April 17, 2014

Dianne Loubier
Ignace
Term: Aug. 21, 2011
to Aug. 20, 2013

Dianne Miller
Thunder Bay
Term: Nov. 18, 2012
to Nov. 17, 2015

Tina Copenace
Kenora
Term: Oct. 18, 2012
to Oct. 17, 2015

Gary Phillips
Thunder Bay
Term: Nov 18, 2009
to Nov. 17, 2012

OUR MISSION

Develop an innovative, sustainable and efficient health system in service to the health and wellness of the people of the North West LHIN.

OUR VISION

Healthier people, a strong health system – our future.

OUR VALUES

1. Person-Centered
2. Culturally Sensitive
3. Sustainable
4. Accountable
5. Collaborative
6. Innovative

Introduction

The past year was one in which the North West LHIN made significant strides towards building an integrated system of care. It was the first full year of the North West LHIN's Health Services Blueprint, and also the year the North West LHIN released its 2013-2016 Integrated Health Services Plan (IHSP III).

Both the Health Services Blueprint and the IHSP III chart a course for a health care system that is more responsive, person-centered, efficient and sustainable, while building on the solid foundation laid by the North West LHIN since its creation in 2005.

Local Health Integration Networks were mandated by the government of Ontario to plan, fund and integrate health services. The principal focus for LHINs has always been integration – the creation of better partnerships between health service providers to improve the patient experience, and achieve better health outcomes.

One key challenge in health care has been balancing quality and value - how to provide the best possible care to patients through the most efficient use of precious resources. It is widely agreed that the answer lies in eliminating duplication, bridging the gaps in service that currently exist, improving access to care, and viewing health care as an undertaking in which every dollar spent results in a better care experience for patients, clients, and their families.

Planning for Better Health Care Services

Delivering health care services that are sustainable requires thoughtful planning to support and enable planning efforts for the North West. The following graphic illustrates the relationship between planning documents, which guide the activities of the North West LHIN:

Ministry Strategic Plan
Ontario's Action Plan for Health Care sets the direction for the health care system provincially

North West LHIN Strategic Plan
The LHIN Board of Directors' Strategic Plan sets the direction for the health care system in Northwestern Ontario

Integrated Health Services Plan (IHSP)
The LHIN planning document that broadly identifies and describes priorities and directions over a three-year period

Annual Business Plan
Plan that describes the annual activities and associated spending plans that will be executed in order to implement the IHSP for the next three years, with emphasis on the upcoming fiscal year

There are a number of initiatives and strategies that work in harmony with the above, such as the Health Services Blueprint and the eHealth Services Plan, to lead health care system transformation that makes sense for Northwestern Ontario.

Health Services Blueprint
Integration. Transformation.
A North West LHIN Initiative

Health Services Blueprint

The Blueprint is a complex and long-term plan, with implementation over the next 10 years. In 2012/13, the North West LHIN worked on 19 of the 44 recommendations, including:

- Identifying services and delivery of care at regional, district, and local levels;
- Collaboration across all health service providers at the local level;
- Defining our Integrated District Network (IDN) geographies;
- Increasing access to home care services within the City of Thunder Bay IDN, District of Thunder Bay IDN, and the Rainy River IDN;
- Improving access to designated mental health and addiction beds, home care services, and post-acute or transitional care beds within the District of Kenora IDN;
- Increasing access to post-acute and transitional care beds, and ensuring access to long-term care services in the Northern IDN;
- Expanding telehomecare and telemedicine; and,
- Establishing regional programs.

Health service providers are absolutely critical to the process of implementing the recommendations; therefore, much of the early-stage work at the North West LHIN has centred on bringing providers together to develop an understanding of the plan and model of care, and to gain a better understanding of the urgency and need for system integration. To read more about the Health Services Blueprint, please visit www.northwestlhin.on.ca.

In spring 2012, the North West LHIN Board of Directors engaged with 266 health service provider Board governors and CEOs from LHIN-funded organizations across Northwestern Ontario. The meetings were held over three months in five communities – a community from each of the five Integrated District Networks as outlined in the Health Services Blueprint. Over the course of these meetings, health service providers were informed about the Health Services Blueprint, including the background on why and how it was developed, recommendations for an integrated health system, data supporting the recommendations and next steps as the North West LHIN moves to implement the recommendations.

The engagement continued in late 2012 with another series of meetings in which the North West LHIN met with nearly 150 senior leaders from health service providers to share the rationale and approach for developing the Blueprint, and to discuss the recommendations and implementation approach.

And in January 2013, more than 180 governors and senior leaders attended a session in Thunder Bay to discuss the next steps in advancing system transformation across the North West LHIN.

Health Links

In December 2012, the Ministry of Health and Long-Term Care (MOHLTC) launched integrated regional patient care networks called Health Links, which place primary care providers at the centre of the system of care. Health Links will encourage greater collaboration and coordination between a patient's different health care providers as well as the development of personalized care plans. This will help improve patient transitions within the system and help ensure patients receive more responsive care that addresses their specific needs with the support of a tightly-knit team of providers.

Both the Health Services Blueprint and Health Links focus on reducing avoidable visits to hospital by providing the right care in the right place at the right time. In the North West LHIN, Health Links will correspond with the five Integrated District Networks (IDN) areas described in the Health Services Blueprint:

1. City of Thunder Bay IDN
2. Thunder Bay District IDN
3. Kenora IDN
4. Rainy River IDN
5. Northern IDN

Collaboration across LHIN-funded and non-LHIN funded providers is an essential component to building an effective integrated health service delivery model in which interprofessional care across the continuum is coordinated and seamless.

Our LHIN, Our People

The North West LHIN is vast. It covers 47% of Ontario's total land mass with boundaries extending east from the Manitoba border to just west of White River, and from Hudson Bay in the north to the United States border in the south. At the same time though, this immense region is just home to 2% of Ontario's population.

The population density of 0.5 people per square kilometre is the lowest in the province. Communities in the North West LHIN are spread across 458,010 square kilometres, which makes planning and delivery of health care services within the Northwest very challenging. This challenge is compounded by the fact that many of the communities are in remote areas with road access only in the winter; others are accessible only by air, year-round.

OUR POPULATION

The 2011 Statistics Canada Census population for the North West LHIN, adjusted for the 13 First Nations communities that did not participate in the Census, is approximately 231,000, a decrease of 1.7% from 2006.

As a whole, like most jurisdictions, the population is getting older. But unlike other areas, the number of people living in this region is shrinking. The North West LHIN has the largest proportion of its population that self-identifies as Aboriginal (approximately 20%) and has the largest proportion of Indian Reserves and settlements in the province (56%)[1].

Some of the key differences in population between Integrated District Networks are:

Population size:

- The City of Thunder Bay accounts for over half (52.6%) of the North West LHIN's population;
- Thunder Bay (city) is the only large, urban centre in the North West LHIN;

Francophone population:

- The Thunder Bay District IDN has the largest proportion of Francophone population (10.5%) while the Northern IDN has the smallest (0.9%);

Aboriginal population:

- The Northern IDN has the largest proportion of Aboriginal population (based on self-identification from the 2006 Census) at 77.8%;
- The City of Thunder Bay IDN has the lowest proportion of Aboriginal population (8.3%) in the North West LHIN, but is still much higher than the provincial value of 2%.

Age of the population:

- The Northern IDN, with the largest Aboriginal population, has the lowest proportion of seniors age 65 and over; and,
- Rainy River IDN and the City of Thunder Bay IDN have the largest proportion of seniors, at slightly over 17% of the total population.

[1] Health Analytics Branch. First Nations Graphical Counts: A Demographic Portrait. Jan. 2009

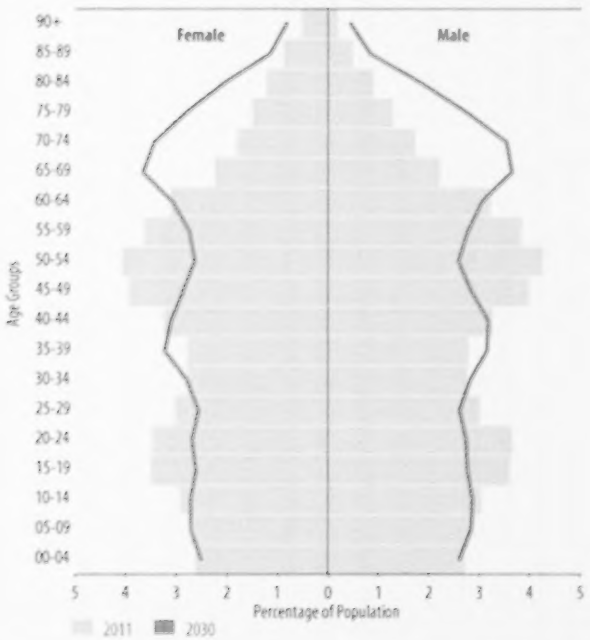
The following table illustrates the differences in the IDN populations within the North West LHIN:

2011 Census Indicators	North West LHIN Integrated District Networks					
	Northern IDN	Kenora IDN	Rainy River IDN	City of Thunder Bay IDN	Thunder Bay District IDN	North West LHIN
Population[1]	21,560[1]	43,130	20,370	121,600	24,460	231,120[1]
% population age 65 and over	6.6%	15.5%	17.3%	17.2%	14.3%	16.0%
% Population of Aboriginal Identity (2006 Census)[2]	77.8%	21.8%	21.7%	8.3%	19.9%	19.2%
% Francophone population	0.9%	2.9%	1.5%	2.7%	10.5%	3.4%

1. 13 First Nation communities in the Northern IDN did not participate in the 2011 Census. Registered Indian population counts as of July 2012 were used to estimate the Northern IDN and total North West LHIN populations.
2. Questions related to Aboriginal identity were not asked in the 2011 Census. Estimates from the new National Population Survey will be available in summer 2013.

The following graph (Population Pyramid) illustrates the projected shift in the North West LHIN population from younger to older age groups between 2011 and 2030:

Population Pyramid



Source: IntelliHealth Ontario.
Population projections LHIN Data Table. Sept. 2010.

POPULATION HEALTH PROFILE

Health Status and Health Behaviours

In comparison to the rest of the province[2], the North West LHIN has a higher:

- Percentage of residents age 12 and over who smoke (23.9% versus 18.9%);
- Percentage of heavy drinkers[3] of those who drink alcohol (20.9% versus 15.9%);
- Percentage of adults who are overweight or obese, based on self-reported height and weight (61.7% versus 52.0%);
- Percentage of residents who are moderately active or active in their leisure time (58.0% versus 50.5%); and,
- Percentage of residents who report being diagnosed with high blood pressure (19.9% versus 17.4% for ages 12 and over; 56.7% versus 49.7% for ages 65 and over).

And a lower:

- Percentage of residents who report they have a regular medical doctor (83.5% versus 91.1%);

2 Statistics Canada. 2013. Health Profile - Statistics Canada Catalogue no. 82-228-XWE. Ottawa. Released January 09 2013. http://www12.statcan.gc.ca/health-sante/82-228/index.cfm?Lang=E

3 Six more drinks on one occasion, at least once a month in the past year

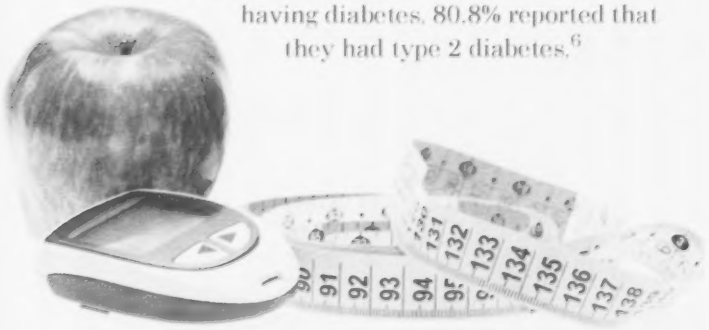
- Percentage of residents who have had contact with a medical doctor in the past year (79.3% versus 82.2%);
- Percentage of residents whose self-rated health is very good or excellent (57.4% versus 61.0%); and,
- Percentage of residents whose self-rated mental health is very good or excellent (68.2% versus 74.3%).

The annual prevalence estimates from the Canadian Community Health Survey for North West LHIN residents have been very consistent over the five-year period 2007 to 2011.

Diabetes

Based on the Baseline Diabetes Data Initiative (BDDI)[4] the number of adults diagnosed with diabetes increased to 22,345 (as of March 31, 2012) representing 11.8% of the adult population[5] in the North West LHIN. This compares to 9.7% provincially.

The First Nations Regional Health Survey (RHS) 2008/10 identified the rate of diabetes for adults aged 25 years or older was 20.7%. There is a higher rate of diabetes in First Nations adults who live on-reserve or in northern communities than among First Nations adults who do not live in First Nations communities. Of those who reported having diabetes, 80.8% reported that they had type 2 diabetes.[6]



Leading Causes of Hospitalization

Based on the most recent hospitalization data (fiscal year 2010/11), North West LHIN residents continue to have higher rates[7] of overall hospital (acute inpatient) use (112.6 discharges/100,000 population versus 71.6 discharges/100,000 population provincially) and for many specific causes including:

- Self-injuries
- Mental illness
- Hip replacement
- Knee replacement

and for a select group of chronic conditions:

- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Congestive Heart Failure

The ambulatory care sensitive conditions[8] (ACSC) rate in the North West LHIN is significantly higher than the provincial rate - 531/100,000 population versus 274/100,000 population, which is presumed to reflect problems in obtaining access to primary care.

Leading Causes of Death

North West LHIN residents continue to have higher mortality rates for all causes of death combined (629.1/100,000 population versus 521.8/100,000 population provincially) and for many specific causes (over the three-year period 2005 – 2007) including:

- Lung cancer
- Circulatory diseases
- Unintentional injuries
- Suicides and self-inflicted injuries

The breast cancer mortality rate for North West LHIN females is significantly lower than the provincial rate (15.5/100,000 females compared to 22.0/100,000 provincially).

Although the mortality rates for many causes are still higher compared to the province, the North West LHIN mortality rates for many causes have decreased since 2000-2002[9], including all malignant cancers, breast cancer, prostate cancer, ischaemic heart diseases and cerebrovascular diseases.

The North West LHIN also has high rates of premature mortality - deaths of individuals who are younger than age 75 (332/100,000 population versus 239/100,000 provincially) and potentially avoidable mortality[10] (252.4/100,000 versus 172.9/100,000 population provincially) based on the three-year average (2007 – 2009). Potentially avoidable mortality is used as a measure of the effectiveness of the health care system.

Life expectancy at birth for North West LHIN residents is 78.6 years compared to 81.5 years for all Ontario residents, based on 2007 – 2009 mortality rates.

ABORIGINAL HEALTH

At 19.2%, the North West LHIN has the highest proportion of Aboriginal people in the province. The health status of Aboriginal people is poorer than their non-Aboriginal counterparts on most measureable health indicators: life expectancy, infant mortality, unintentional injuries, chronic disease (e.g. diabetes, asthma, heart disease, HIV/AIDS), infectious disease (e.g. tuberculosis, pneumonia) and hospitalizations. In addition, the suicide rate among First Nations, Inuit and Métis youth is between five to six times higher than the non-Aboriginal youth population. Suicide is the leading cause of death for First Nations people between the ages of 10 and 44.

Access to the full range of health care services for Aboriginal people living in First Nations communities continues to be a challenge for a variety of reasons which include geography, remoteness, language, and jurisdictional issues. These barriers to care contribute to inequitable access and affect the quality of care delivered.

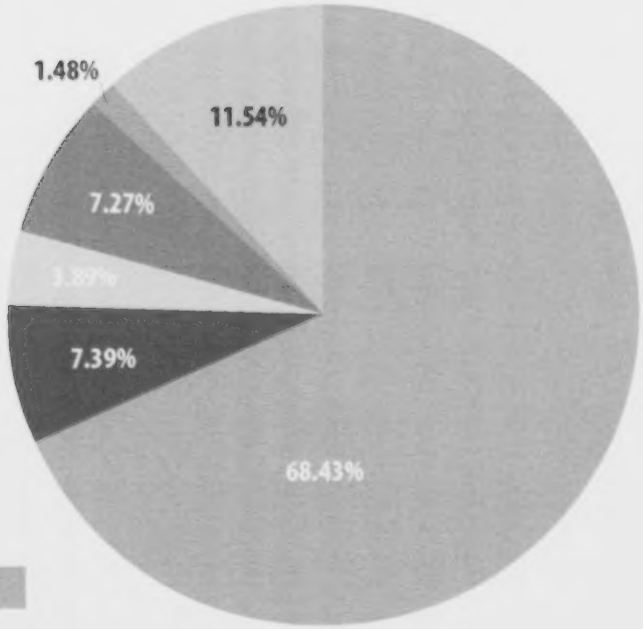
To address these barriers, while Aboriginal community engagement has been a priority of the North West LHIN over the past several years, greater collaboration and partnership with the Aboriginal community is still required. In addition, collaboration and partnerships are essential between and across local, municipal, provincial and federal governments to continue to improve and to integrate the delivery of health services across the care continuum. Key planning areas involve developing a mental health and addictions substance abuse strategy focusing on children, youth, and adults as well as strategies to improve access to chronic disease prevention and management services to meet these population needs.

FRANCOPHONE HEALTH

Only 45% of Francophones in the North West LHIN perceive their health as very good or excellent, compared to 62% of all Francophones in Ontario. In addition, the proportion of North West LHIN Francophones reporting that they have a medical doctor is significantly lower than for all Ontario Francophones (69% compared to 88%, respectively).
There are two pieces of legislation that guide French language services in Ontario – the Local Health System Integration Act and the French Language Services Act. In accordance with this legislation, the North West LHIN is working in partnership with the Réseau du mieux-être francophone du Nord de l'Ontario, which is the French Language Health Planning Entity for the North West LHIN, to engage the Francophone population. Through work with health service providers, the ultimate goal is to improve access to services in French and to achieve better health outcomes for the Francophone population in Northwestern Ontario.

North West LHIN Funding Allocation by Sector, for 2011-2012 (Ministry-LHIN Performance Agreement) as of July, 2012

- Hospitals (13)
- Community Care Access Centre (1)
- Community Support Services (61)
- Community Mental Health and Addictions Services (34)
- Community Health Centres (2)
- Long-Term Care Homes (14)



Total number of Health Service Provider (HSP) programs or operations 125

Total number of HSP organizations 93*

Total $600,480,256

*Note: This represents the number of individual Health Service Providers (HSPs) funded by the North West LHIN as of April 1, 2013. Some HSPs funded by the North West LHIN provide service in multiple sectors.

North West LHIN Facts

- The North West LHIN budget is $600 million.
- 93 health service providers.
- Health care costs are 39% higher than the provincial average.
- 93% of seniors want to live at home.
- We have 131% higher use of the emergency department for diabetes than the provincial average.

Health System Advancements in 2012-2013

INTEGRATED HEALTH SERVICES PLAN

The Local Health System Integration Act, 2006, under which LHINs were created, requires all of Ontario's 14 LHINs to develop and publish Integrated Health Services Plans (IHSPs). These are high-level, three-year roadmaps for the planning and delivery of health care in each LHIN's region. They identify and anticipate health care needs and priorities, and advance plans to meet them.

The North West LHIN's first IHSP was mainly concerned with establishing the organization within the Northwestern Ontario health care community. The second IHSP, by contrast, focused on making significant progress on a number of fronts. The plan, which was informed by extensive research and engagement with both health care stakeholders and members of the public, identifies 11 priorities for health care in the Northwest.

These have been broken out into three broad areas:

Access to and Integration of Services

1. Emergency Department Wait Times and Alternate Level of Care
2. Primary Care
3. Specialty Care and Diagnostic Services
4. Chronic Disease Prevention and Management
5. Long-Term Care Services
6. Mental Health and Addictions Services

Enablers

7. Health Human Resources
8. eHealth
9. Integration along the Continuum of Care

People of Northwestern Ontario

10. Aboriginal Health Services
11. French Language Health Services

This past year marked the final year of the North West LHIN's *Integrated Health Services Plan 2010-2013*.

ACCESS TO AND INTEGRATION OF SERVICES

Emergency Department Wait Times and Alternate Level of Care

The problems of emergency department wait times and alternate level of care days are closely linked. For many people, emergency department wait times are one of the most important ways by which health systems are measured. People may not always understand the causes of the delays that they face, but they understand at a basic level that it often takes too long for them to receive the care they require.

Alternate level of care days are less easily understood. The term refers to the number of days that a patient spends in hospital, when he or she should in fact be receiving more appropriate care in an alternate setting.

The two issues are closely linked and result from increased use of hospital resources, and limited resources in the community for aftercare.

Improving Emergency Department Wait Times

During the 2012/13 fiscal year, the North West LHIN continued to be a top performer in the province for emergency department wait times, with low acuity patients not requiring admission to hospital remaining at 3.9 hours (at the 90th percentile), and high acuity patients not requiring admission staying at 6.7 hours (at the 90th percentile), well within the provincial target of seven hours.

Repeat unscheduled emergency visits within 30 days for substance abuse conditions have increased slightly from 28.42% in 2011/12, to 29.51% in 2012/13, while the number of repeat unplanned emergency visits within 30 days for mental health conditions decreased from 18.20% to 17.45%.

To support our emergency departments, the North West LHIN has:

- Provided funding to support the study of medically-necessary, non-urgent transportation to the west of Thunder Bay. The study will generate redesign options for an integrated system of non-urgent transportation within and among Integrated District Networks;
- Supported the implementation of an eCredentialing project led by Thunder Bay Regional Health Sciences Centre (TBRHSC) that focused on decreasing the time it takes to process physician credentials. This is essential to hospitals in Northwestern Ontario that are heavily reliant on locum coverage for emergency departments;
- Continued the Emergency Department Pay-for-Results (P4R) program at TBRHSC that focused on implementing initiatives to reduce emergency department wait times and to improve efficiency and patient flow through the hospital. This past year, a Geriatric Emergency Medicine nurse was put in place to screen high risk seniors; and,
- Supported the implementation of evidence-based common order sets for individuals admitted to hospital.

It is important to note that while a great deal of progress was made in the past year, there is much more to be done. Overall, wait times for individuals requiring admission to hospital in the North West LHIN increased over the previous year. In 2012-2013, 10% of patients requiring admission waited more than 31 hours in the emergency department.

Reducing Alternate Level of Care Days

Over the past year, the percentage of alternate level of care (ALC) days in the North West LHIN decreased by more than 2% to 16.53%. This is well within the target of 19% for 2012/13.

The North West LHIN invested approximately $3.7 million dollars in new initiatives across the region to support ongoing programming aimed at reducing ALC pressures across the Northwest. These initiatives are designed to improve access to community-based health services, avoid unnecessary visits to the emergency department, lower hospitalization rates, and expedite discharge from the hospital. They include:

- Funding to improve access to opiate dependency treatment for pregnant and parenting mothers, adults, and transitional-aged youth;
- Increasing personal support worker hours by 19,727 through investment with the North West Community Care Access Centre (CCAC);
- Addition of 1,460 alternate care days through four units of assisted living services: two units of assisted living services for individuals with acquired brain injury at Brain Injury Services of Northern Ontario (BISNO), and two units of assisted living services for individuals with physical disabilities at HAGI Community Services for Independence; and,
- Investment in two additional units of assisted living space for high-risk seniors in Kenora, providing seniors with care in the right setting, and alleviating 730 alternate level of care days that could have been spent in hospital.

The North West LHIN continued to support ongoing programming aimed at reducing ALC pressures, such as the Assess & Restore programs in Thunder Bay, Kenora and Dryden, and the Nurse-Led Outreach Program in Thunder Bay.

Home First

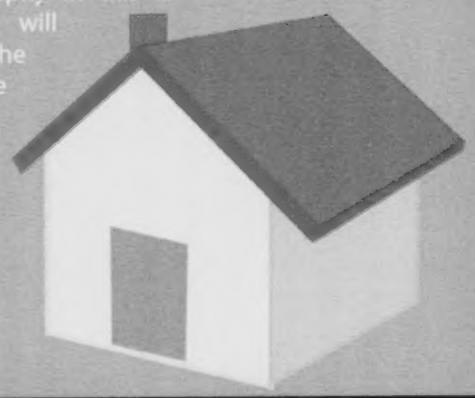
Home First is a philosophy of care, rather than a program. Introduced in September 2010 as a new way of thinking and approach to person-centered care, Home First seeks to change the long-established pattern of having older patients remain in hospital or be placed directly into long-term care when in fact, with the right community supports in place, their health care needs could be addressed at home.

With the Home First approach, care providers in the hospital work together with North West CCAC case managers and other health system partners in the community to explore all possible patient discharge options for safe transition to home.

At Thunder Bay Regional Health Sciences Centre, the introduction of the Home First philosophy and increased community support services in the City of Thunder Bay have produced measurable results. Between September 2010 and the end of April 2013, there has been:

- A 38% reduction in ALC clients (87 to 54) and a 50% reduction in ALC clients waiting for long-term care (34 to 17) at this site;
- A 25% increase in discharges to the community with supports from 2,648 in 2009-2010 to 3,320 in 2011-2012; and,
- A 31% decrease in discharges with ALC involvement to long-term care homes, from 169 to 117.

Since the implementation of the Home First philosophy at Kenora's Lake of the Woods District Hospital in November 2011, the total number of ALC clients was reduced from 24 to seven by March 31, 2013. At the same facility, the total number of ALC clients waiting to be discharged to long-term care was reduced from 15 to three. It is expected that the continued implementation of the Home First philosophy in this community will maintain the gains made in reducing ALC.



Access to Primary Care is Enhanced to Keep People Healthy

The first point of contact into the health care system for most patients is through primary care, whether it's a family physician or a nurse practitioner. Because access is an issue in the North West LHIN, much of our focus this past year was to support opportunities for expanding Nurse Practitioner-Led Clinics and additional Family Health Teams.

Two Nurse Practitioner-Led clinics exist in Thunder Bay and a total of 15 Family Health Teams are now in place across the Northwest region, including teams in Nipigon, Manitouwadge, and Thunder Bay.

As of March 2013, the North West CCAC's Health Care Connect program linked 41.97% of registered individuals with a primary care provider, up from 39% last year. That means that over the past year, about 1,000 people were matched to a primary care provider.

In addition, two Community Health Centres (CHCs) operate in the North West LHIN – the Mary Berglund Clinic and the NorWest CHC. Community health centres have been very successful in reaching hard-to-serve marginalized populations, connecting unattached patients to primary care providers, offering mobile services to frail seniors in their homes and offering outreach services to geographically dispersed areas of our region.

NorWest CHC's Diabetes Mobile Unit

Over the past year, the Diabetes Mobile Unit has:

- Made 72 visits to the community;
- Recruited 25 new clients;
- Seen 525 footcare clients;
- Met with 212 wound care clients; and
- Scheduled 54 client appointments with a dietitian.

Offering primary care within the community supports those who do not have or are unable to access a primary care physician, and diverts people from the emergency department.

Three Aboriginal Access Centres are funded by the North West LHIN and are located in Kenora, Fort Frances, and Thunder Bay. Over the past few years, the North West LHIN has worked to improve collaboration and linkages with the primary care physicians serving the Northern First Nations communities.

The North West LHIN's Primary Care Physician Lead has been in place since January 2012. Dr. Ric Almond has played an instrumental role in improving linkages and access to primary care health services in the community. Dr. Almond has engaged with all primary care providers across the North West LHIN this past year, including emergency physicians. Through his efforts, there is better communication, coordination and information sharing between hospital, community and primary care providers. For example, nurse practitioners were not receiving discharge notes for the patients in their care. As a result of the improved communication channels that Dr. Almond has nurtured and developed, nurse practitioners in the region now receive discharge summary notes in a timely manner.

Improving Access to Specialty Care and Diagnostic Services

Cancer and Cataract Surgery

In 2012/13, the North West LHIN continued to lead the province in wait times for cancer and cataract surgery:

- The wait time for cancer surgery has remained at 38 days, well below the North West LHIN target of 45 days; and,
- The wait time for cataract surgery is below the North West LHIN target of 115 days, at 111 days for 2012/13.

Both of these wait times are well within provincial targets and clinical guidelines.

Hip and Knee Replacement Surgery in the 90th Percentile

In its 2013 report on wait times, the Canadian Institute for Health Information found that despite a 15% increase in the number of joint replacements

carried out Canada-wide between 2010 and 2012, the number of procedures carried out within target (182 days) was down by 4% for both hips and knees.

At the 90th percentile, wait times for hip replacement surgery in the North West LHIN increased slightly from 194 days in 2011/12, to 206 days in 2012/13. This wait is within what is considered to be an acceptable performance range, but it is above the current North West LHIN target of 176 days. Wait times for knee replacement surgeries in the North West LHIN increased by nine days to 225 days in 2012/13, compared to 216 days in the previous year. This increase was primarily driven by patients who elected to wait for their surgery.

Despite increased wait times in some specialty surgical care areas, there were important advancements made in this area over the past year. Through a coordinated effort at Thunder Bay Regional Health Sciences Centre (TBRHSC), the region's largest surgical site for hip and knee replacements, adoption of best practice clinical pathways resulted in 92% of patients being discharged to home after a primary unilateral hip or knee replacement, up from 59% one year ago.

The North West LHIN has embarked on the creation of a regional surgical services model for orthopaedics. The first phase of this project involved the completion of an Integrated Orthopaedic Capacity Plan. The new regional model will focus on providing care as close to home as possible, reducing wait times for surgery, increasing quality of care, and expanding on successful innovations such as the Regional Joint Assessment Centre and the Inter-professional Spine Assessment and Education Clinic.

Diagnostic Imaging

During the past year, there was a decrease in funded hours of service for diagnostic imaging. For Magnetic Resonance Imaging (MRI) scans, wait times increased from 78 days in 2011/12 to 114 days in the current year. However, wait times for Computerized Tomography (CT) scans decreased from 40 days to 35 days over the course of the year.

The North West LHIN has engaged stakeholders throughout the year to determine how diagnostic imaging wait times and performance can be improved through increasing appropriateness of referrals. TBRHSC is currently participating in a pilot project where physicians have access to provincial evidence-based clinical guidelines about test appropriateness before making requests for diagnostic imaging. Stakeholders engaged over the past year have indicated that, by focusing on appropriateness of diagnostic testing, there is the potential to reduce the demand for wait times for this service.

Better Chronic Disease Prevention and Management Prevents Hospitalization

One in three Ontarians is affected by chronic disease, which is commonly defined as a long-term disease that can be treated but not cured. Chronic diseases are the leading causes of death in Canada and Ontario. In this province, heart disease, stroke and cancer combine to account for 60% of all deaths, nearly doubling all other causes.

It is widely accepted that the best approach to managing chronic disease is to involve patients in taking an active role in their own care, with the help and support of their health providers. Much of the care in this situation can be done at home and in the community. Given that in Ontario the economic burden of chronic disease is estimated to be 55% of total direct and indirect health costs, there is significant pressure on all LHINs to improve chronic disease prevention and management in their regions.

Management of chronic disease is a vital component of any sustainable health care system, and the North West LHIN continues to work closely with health service providers to shift the model of care and move clients from reliance on inpatient care to outpatient community-based care. Over the past year, successes include:

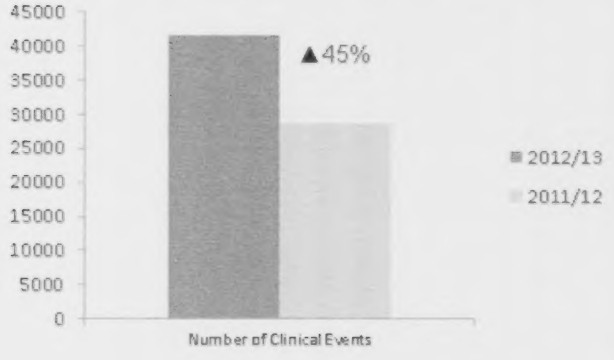
- Increased self-management capacity through the Healthy Change program offered by the North West CCAC in conjunction with St. Joseph's

Care Group. More than 800 people with chronic conditions received support, and more than 200 health professionals received training to integrate self-management into their clinical practice;

- More than 300 people served per year through telehomecare programs for heart failure and chronic obstructive pulmonary disease at TBRHSC, reducing readmissions in the targeted population by over 20%; and,
- Establishment of a new regional wound management program at St. Joseph's Care Group. This virtual program provides consultation for complex wound management across the entire North West LHIN region.

In the fall of 2011, the North West LHIN provided funding for the hiring of 28 additional telemedicine nurses in the Northwest, and saw an increase in clinical visits of 45% over the past year.

Ontario Telemedicine Network Clinical Events for Northwestern Ontario: 2011/12 and 2012/13



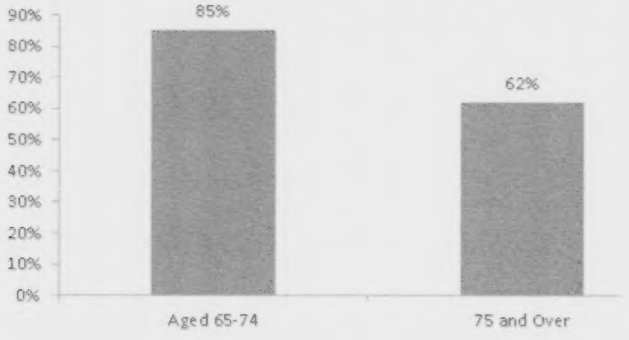
Late in 2012, the Ministry of Health and Long-Term Care began the process of transitioning the province's Diabetes Education Programs over to LHINs. In the North West LHIN:

- 11 of the 18 programs previously managed by the Northern Diabetes Health Network were transitioned to the North West LHIN on December 1, 2012. Going forward, the North West LHIN will have responsibility for the integration of diabetes services across this region;
- The Diabetes Mobile Unit, managed by the NorWest CHC, met with clients 2,351 times in 2012/13. This innovative program, which offers foot care, wound care, and appointments with nurse practitioners and dietitians, meets the needs of people who would otherwise have difficulty accessing timely diabetes management services and diverts people from using the emergency department through prevention and care; and,
- As of October 2012, the Complex Centre for Diabetes Care at TBRHSC extended diabetes services to inpatients, targeting prevention of readmission and reduced length of stay. The Centre, which provides full interprofessional care, now has over 500 rostered patients, more than 150 of whom have no primary care provider. Regionally, a satellite location was established at the Sioux Lookout Meno Ya Win Health Centre.

Long-Term Care Services

Like many jurisdictions, the North West LHIN faces a serious challenge in providing health care and support to its rapidly aging population.

By 2030, the Seniors Population in Northwestern Ontario is Expected to Increase:



It is understood that seniors want to stay at home as long as possible, and in Northwestern Ontario, 32% of seniors in the region live alone, compared to 25% provincially.

The North West LHIN has developed a model of care based on best practice that outlines the level of services required to support a senior to stay at home in the community:

- 85% of seniors can live independently with infrequent use of community support services;
- 7% of seniors require lower needs community support services;
- 3% of seniors require higher needs supportive housing and community support services; and,
- 5% of seniors require long-term care.

The model of care to support seniors to stay at home in the community has led to an:

- Increase in North West CCAC services by 5% to support the high risk seniors population, and to address alternate level of care pressures in hospital;
- Expansion of access to care through telemedicine by 59%; and,
- Increase in the number of assisted living units in the North West LHIN by 63% since 2010, from 298 units to 486. The largest recent increase in these services was the opening of the 132-unit Sister Leila Greco Assisted Living site at St. Joseph's Care Group, which introduced 57 net new units to the City of Thunder Bay in 2012/13.

The North West LHIN, in partnership with St. Joseph's Care Group and the End of Life Care Network, is developing a regional palliative care plan. This comprehensive plan will focus on palliative care in the community, end of life care for people with chronic conditions, and access to a 24/7 expert clinical team across the North West LHIN. The plan will be complete in June, 2014 with implementation to follow.

Mental Health and Addictions Services

While progress is being made in the way we deal with mental illness and addictions, it remains true that people suffering from these conditions are among the most vulnerable in society. Mental illnesses and addiction issues are generally not well understood by the general public, and stigmas persist. People with mental illness and/or addictions are often isolated and have difficulty navigating the health care system.

Since last year, the number of repeat unscheduled emergency department visits within 30 days for substance abuse conditions has increased slightly from 28.42% to 29.51%, while the number of repeat unscheduled emergency visits within 30 days for mental health conditions has decreased from 18.20% to 17.45%.

In February 2013, the North West LHIN announced the funding for a pilot project for 22 crisis management and stabilization beds at St. Joseph's Care Group's Balmoral Withdrawal Management Centre. This change will see the conversion of Balmoral Centre from a Level 2 non-medical facility with seven crisis management beds, to a Level 3 facility, with 24-hour nursing support. This change is expected to divert more than 1,000 emergency department visits per year and improve access to care for those individuals requiring this service.

The Ontario government introduced a comprehensive Mental Health and Addictions Strategy called *Open Minds, Healthy Minds* in June 2011. The North West LHIN is well aligned with that strategy, and in the past year, has made significant progress towards improving the lives of some of the most vulnerable people in this region.

The North West LHIN implemented its Behavioural Supports Ontario (BSO) action plan, which includes the creation of a Regional Behavioural Health Service at St. Joseph's Care Group to oversee the care of older adults with responsive behaviours in the North West LHIN.

The rollout of this plan included:

- Funding of 20.6 (FTE) front-line workers to support new programs, services, and training, as well as to enhance care delivery for individuals living with responsive behaviour in long-term care homes and in the community;
- Creation of a System Navigator position at the North West CCAC that assists clients and their families in accessing appropriate services for care of responsive behaviours;
- Establishment of two regional mobile teams – one in Fort Frances, and the other in Thunder Bay – which, working with Psychogeriatric Resource Consultants, will create individualized care plans within the long-term care setting to help stabilize behaviours; and,
- Training for more than 2,400 individuals from across the region on the management of responsive behaviours.

Other types of community support funded through the North West LHIN included:

- Establishment of a 24-bed specially designated transitional behavioural support unit at Hogarth Riverview Manor, which will assist in management of acute responsive behaviours within a specialized environment with the goal of transitioning the client back to the original long-term care setting;
- Trained and educated more than 120 children and youth on mental health and addictions through a service collaborative with the Centre for Addiction and Mental Health (CAMH);
- Funded 11 nurses with the CCAC to work with school boards to address mental health and addictions education for children and youth; and,
- Transitioned the Getting Appropriate Personal and Professional Supports (GAPPS) program from a three-year pilot to a permanent program.

Getting Appropriate Personal and Professional Supports (GAPPS)

The Getting Appropriate Personal and Professional Supports (GAPPS) program in Thunder Bay, initially a three-year pilot project funded by the North West LHIN, saw a team of care providers from Alpha Court, the Canadian Mental Health Association, the NorWest Community Health Centre and St. Joseph's Care Group provide services in non-traditional locations such as shelters, food banks, soup kitchens, streets and a withdrawal management centre.

In 2012/13, the GAPPS program was made permanent due to the success of the three-year pilot.

Since its inception, the GAPPS program has:

- Served **1,244** individuals;
- Made **17,141** contacts with clients; and
- Decreased the frequency of emergency department visits amongst high users by **60%** following discharge from the GAPPS program.

Enablers

HEALTH HUMAN RESOURCES

A major focus in the past year was to ensure that hospitals in our region have appropriate emergency department coverage. The North West LHIN has worked closely in collaboration with its health care providers as well as broader system stakeholders such as Healthforce Ontario (HFO), the Underserviced Area Program of the Ministry of Health and Long-Term Care (MOHLTC) and its Primary Care branch.

The North West LHIN is pleased to say that in 2012/13, there were no emergency department closures in the region due to lack of physician coverage.

The North West LHIN monitors the Health Care Connects Program operated, by the North West CCAC. Over the past three years, there has been a significant improvement in the numbers of unattached patients registered through Health Care Connects linked to a primary care resource in the community. More than 41% of those registered are now linked to a primary care resource in the community, whether it is a community health centre, a nurse practitioner, or a primary care physician. The North West LHIN is aware that there is still a long way to go to fill the gaps created by recent physician retirements, particularly in the City of Thunder Bay, and that there are a high number of unattached patients in the Kenora area.

The North West LHIN partnered with the North Superior Workforce Planning Board and the Northwest Training and Adjustment Board to conduct an environmental scan of current health human resource capacity within the health sector. The study predicts retirements and vacancies over the next five to 10 years, and assesses future health care sector recruitment and retention needs within each of the Integrated District Networks as outlined in the Health Services Blueprint. Specific occupational needs will be determined on a district-by-district basis. This information will help inform the Health Services Blueprint implementation plan. The scan was completed in March 2013.

EXPANDING THE ADOPTION OF eHEALTH TO ENHANCE SAFETY, IMPROVE DECISION-MAKING, AND INCREASE PATIENT SATISFACTION

The reality of health care in the 21st century is that it depends on eHealth – the electronic storing, managing and sharing of information – to be truly efficient, effective, and agile. In 2012/13, the North West LHIN continued to move health care in the region away from the old paper-based information system towards a future state where all important information will be available electronically, to the people who need it, when and where they need it.

This past year, the North West LHIN continued to work closely with eHealth Ontario to ensure that Northwestern Ontario is aligned with the provincial strategy to implement the interoperable Electronic Health Record (iEHR), which will enable authorized health care providers to view and, in some cases, update a patient's essential health information.

Other achievements include:

- In 2012/13, the North West LHIN completed six integrations from clinical systems to regional/provincial systems increasing the sharing of clinical information, enabling timely patient care decisions, ultimately resulting in more efficient and effective care;
- The integration of electronic medical records with hospital information continues, with information flowing seamlessly between 12 hospitals and 35 clinics in the Northwest;
- As of December 2012, approximately 72% of family physicians in the North West LHIN have adopted electronic medical records – the fifth highest percentage in the province. That is an increase of 10% from last year; and,
- By the end of this past year, more than 300,000 reports were electronically transmitted from hospitals to clinician systems.

Along with partner LHINs North East, Champlain and South East, the North West LHIN has been participating in planning the Connecting Northern and Eastern Ontario (cNEO) project. cNEO is a $40 million project funded by eHealth Ontario that will provide health service providers with timely access to personal health information from across the continuum of care – at any point – throughout the cNEO region. This past year was focused on the detailed planning efforts required to implement the vision and included a strong focus on regional readiness activities and planning for change management and adoption, to ensure the upcoming implementation will be successful.

The North West LHIN continued to participate on a project that improves the way patient referrals flow through the system with the Alternate Level of Care Business Transformation Initiative. Health care providers in the North West, North East, Champlain and South East LHINs are moving closer to a standard referral form for patients on the Hospital to Rehabilitation Services and Hospital to Complex Continuing Care pathways. An improved and standardized referral process increases system performance, improves the patient/client experience and ensures all individuals have equitable access to safe and optimal care.

The implementation of an Electronic Patient Chart, or eChart, for patients of Regional Cancer Centre North West continued in the past three years. This large multi-year project will provide a centralized paperless chart for all patients who receive cancer treatment in the North West LHIN region. Patient information will be available for all clinicians who provide care, regardless of where the treatment is delivered.

INTEGRATION ALONG THE CONTINUUM OF CARE

The North West LHIN's Health Services Blueprint is the clearest indication so far of this organization's commitment to further integration. At any given time, the North West LHIN supports or funds multiple initiatives across the region that contribute to greater integration along the continuum of care. Over the past year, these have included:

- The voluntary integration of Patricia Region Senior Services with the Grace Haven Adult Day Program;
- The voluntary integration of Sunset Country Psychiatry Survivor's Group and the Canadian Mental Health Association in Fort Frances;
- The cessation of Audiology Services at St. Joseph's Care Group (private operators in the City of Thunder Bay have taken on these services); and
- Clinical integrations such as the use of common order sets for physicians by small hospitals outside of Thunder Bay, and the use of common assessment tools for community assessments and for mental health and addictions to give consistency and improve clarity in the assessment and transferring of patients within and between care settings.

New in 2012/13 is the Health Services Integration Fund (HSIF), a five-year, $80 million Health Canada initiative to support collaborative planning and multi-year projects aimed at better meeting the health care needs of First Nations, Métis, and Inuit people in Canada.

HSIF is intended to improve the integration of health services, health planning between federal and provincial health systems, and sustain system change through a focus on intra-provincial projects aimed at improving integration and access to existing provincial/territorial and federal health services to better meet the health care needs of Aboriginal people.

HSIF initiatives address one or more of the priorities as described in the Ontario Health Service Integration Plan:

1. Mental Health and Addictions with a focus on prescription drug abuse;
2. Diabetes Prevention and Management;
3. Public Health; and,
4. Data Management.

Seven Health Canada-approved projects are being implemented by First Nations communities in the North West LHIN. Each project has established an Advisory Committee to oversee the project for the next three years. North West LHIN representatives on the Advisory Committee provide guidance and direction throughout the project on integration opportunities at the policy, program, services and/or funding levels between the federal, provincial, LHIN and First Nations communities. All proposed project activities are consistent with the North West LHIN strategic directions; specifically, to improve the health of the Aboriginal population, improve access to care and integration of health services specific to mental health and addictions.

Improved Health Outcomes & Continuous Quality Improvement

In October, 2012, the North West LHIN received more than $3.4 million in one-time funding for small, rural and northern hospitals, to improve access to patient care and to enhance integration and collaboration between hospitals and community care partners. The North West LHIN issued a formal call for proposals in November 2012, and, using a comprehensive decision-making framework, approved 13 projects at eight hospitals across the region.

Some of the initiatives include cross-cultural sensitivity and patient safety training, Resource Matching and Referral expansion and a study to find solutions to address non-urgent and non-emergency transportation issues in the region.

Once successfully implemented, these projects will:

- Ensure patient access to core acute services;
- Respond to community needs for post-acute and palliative services;
- Improve the quality and safety of services for patients while ensuring good value for money; and
- Address inefficiencies in the health system to reduce costs, while maintaining high quality health care services.

The Small, Rural and Northern Hospital Transformation Fund is a unique opportunity to foster a truly integrated approach to person-centred care. These projects will serve not only the strategic priorities of each hospital but greatly benefit patients, families, communities and the local health system as a whole. All of the projects demonstrate the North West LHIN's commitment to move forward with the province's Action Plan for Health Care.

Advancing Person-Centred Care in Northwestern Ontario

In November 2012, the North West LHIN invested approximately $3.7 million in local programs to provide care to more seniors in their homes, reduce unnecessary emergency room visits and readmissions, decrease the number of patients waiting for alternate levels of care, and increase local addiction services.

The North West LHIN invested in:

- Community drug addiction programs in Thunder Bay, Kenora and Sioux Lookout to increase narcotics addiction outreach, case management and withdrawal management for pregnant and parenting moms, adults and youth;
- Assisted living services for seniors in Kenora and for clients in Thunder Bay with an acquired brain injury or physical disability;
- Maintaining the gains of Home First to continue to move seniors in Thunder Bay and Kenora home from hospital, with appropriate home care and supports to heal and get better and support people to remain in their home;
- Additional personal support worker hours to additional high needs clients at risk of hospitalization or long-term care placement; and
- Telehomecare expansion for people with chronic conditions.

These investments will reduce avoidable hospital readmissions by 20%, resulting in nearly 2,000 avoided hospital days related to chronic conditions. Also, the North West LHIN expects more than 300 people struggling with addictions to narcotics, mainly pregnant or parenting mothers, will get more help and more care in their community, as close to home as possible.

Community Engagement

At the North West LHIN, we continuously strive for increased engagement with stakeholders at the local level. It is a crucial component of the North West LHIN's role as a system leader.

In 2012/13, we engaged with 6,942 individuals, stakeholders and organizations at 821 sessions across the Northwest at forums, roundtable discussions, meetings, workshops and training, and through survey tools. That is a slight increase in the number of individuals engaged in the previous year, which was 6,705 over 880 sessions. Participants in community engagement range from community members and leaders, educators, municipal, provincial and government officials, other ministries and jurisdictions, as well as other funding agencies.

Much of that engagement focused on the Health Services Blueprint, as well as local implementation of provincial strategies such as Home First, Behavioural Supports, mental health and addictions, emergency department wait times, alternate level of care,

chronic disease management, seniors care, quality improvement initiatives, Francophone and Aboriginal services, and other North West LHIN activities.

As part of the development of the North West LHIN Integrated Health Services Plan 2013-2016, we conducted a survey between August 20 and September 14, 2012 entitled *Your Region, Your Health Care, Your Voice!* More than 1,200 people from across the North West LHIN responded: 69 of the respondents were Francophone (the survey was offered in French).

ABORIGINAL HEALTH SERVICES

The North West LHIN continues to work towards improving the health status and access to health services for Aboriginal, First Nations, and Métis populations throughout the North West LHIN. These populations represent 19.2% of the overall population of the Northwest region.

Community engagement activities with Aboriginal health services providers in the Northwest have continued over the past year, providing support in the preparation and completion of health services plans, financial reports, service accountability agreements, and providing information on the Health Services Blueprint and the Integrated Health Services Plan priorities.

To ensure a culturally-safe and accessible health care system, the North West LHIN has encouraged health service provider boards and staff to promote cultural awareness and training of staff within their care settings. With the assistance of Sioux Lookout Meno Ya Win Health Centre (SLMHC), training sessions on cultural diversity are being planned across the region. In addition, Cultural Competency Indicators have been developed to assist and encourage the region's hospitals and health care providers to promote and improve access to culturally-appropriate care for all Aboriginal clients.

Photograph, provided courtesy of the Ontario Telemedicine Network

As well, twice annually, the North West LHIN meets with Aboriginal Health Directors from 69 First Nations. The focus this year continues to be on mental health and addictions, long-term care services, palliative care, diabetes management and reporting requirements.

Engagement with Aboriginal communities and health service providers has focused largely on creating awareness of the Health Services Blueprint and our Integrated Health Services planning priorities. At the same time, the North West LHIN receives valuable feedback about the challenges people face living in these remote communities.

FRENCH LANGUAGE SERVICES

The North West LHIN spent the past year working to improve access to French language health services. In March 2013, the French Language Health Planning Entity submitted a report to the North West LHIN that reflects the priority concerns and needs of the Francophone population in our region.

French Language Services Implementation Plans were received from 17 organizations. The recommendations will be used to help inform the planning effort.

CBC News File Photo

Engagement with Broader Stakeholders to Address the Needs of Aboriginal Communities

For the second year in a row, the North West LHIN worked with Emergency Measures Ontario and our health service providers and partners to coordinate health care services for evacuees. Last summer approximately 3,000 people were evacuated from small, rural and remote First Nations communities to communities across the province due to flooding concerns, and the smoke and threat of forest fires in Northwestern Ontario.

The North West LHIN's primary role in these evacuations is to assist in linking health care resources to support the needs of frail and medically-compromised individuals. The North West LHIN commends all of the health service providers and communities involved in the evacuation process for their dedication during the time of emergency. Their skill and compassion made a real difference in the welfare of people with health needs during a stressful time.

Ministry-LHIN Performance Agreements

The North West Local Health Integration Network (LHIN) and the Ministry of Health and Long-Term Care have negotiated an agreement which defines the obligations and responsibilities of both the North West LHIN and the Ministry for the period 2012/13.

The agreement includes a number of schedules which outline how the North West LHIN is to carry out activities related to areas such as Community Engagement, Planning and Integration, Local Health System Management, Financial Management and Local Health System Performance and eHealth.

This type of agreement is mirrored in the accountability agreements that LHINs have negotiated with health service providers such as hospitals, multi-sector agencies and the long-term care sector.

Report on MLPA Performance Indicators

The Ministry-LHIN Performance Agreement (MLPA) for 2012/13 sets out performance indicators and performance targets for the local health system. The North West LHIN works with health service providers to achieve the targets.

In addition to the details provided on wait times performance related to ALC (on page 16), emergency department wait times (on page 15) and surgeries and diagnostics (on page 17-18), in 2012/13, the North West LHIN:

- Maintained wait times at 32 days for clients requiring North West CCAC services in the community. This response time is linked to the increased investment in community services under the Home First initiative, and was achieved despite increased service pressures placed on the North West CCAC with the closure of a long-term care home in the North West LHIN;
- Maintained performance in the area of hospital readmission rates, with the readmission rate for select case mix groups remaining at 16.8%. This performance is also linked to the successful maintenance of the Home First philosophy; and,
- Realized a decrease in the area of emergency department utilization for patients with mental health related conditions with the rate of repeat emergency department visits decreasing from 18.20% to 17.45%. Rates of repeat emergency department visits for substance abuse related conditions increased from 28.42% to 29.51%. During 2012/13, the North West LHIN made significant investments in the areas of supportive housing for mental health and addictions withdrawal management services. These investments are expected to reduce the rates of repeat emergency department visits for mental health and substance abuse in 2013/14.

Table 1 outlines indicators measured in the North West LHIN in 2012/13.

Performance Indicator	LHIN 11/12 Starting Point	LHIN 12/13 Target	Most Recent Quarter 12/13	Annual Results	LHIN Met Target Yes/No
1. 90th Percentile Wait Times for Cancer Surgery*	37	45	41	38	Yes
2. 90th Percentile Wait Times for Cataract Surgery*	103	115	113	111	Yes
3. 90th Percentile Wait Times for Hip Replacement*	194	176	223	206	No
4. 90th Percentile Wait Times for Knee Replacement*	216	182	232	225	No
5. 90th Percentile Wait Times for Diagnostic MRI Scan*	78	59	94	114	No
6. 90th Percentile Wait Times for Diagnostic CT scan*	40	28	27	35	No
7. Percentage of Alternate Level of Care Days - by LHIN of Institution**	18.59%	19.00%	17.72%	16.53%	Yes
8. 90th Percentile ER Length of Stay for Admitted Patients*	29.13	25.00	29.17	31.00	No
9. 90th Percentile ER Length of Stay for Non-Admitted Complex Patients*	6.68	6.50	6.67	6.78	No
10. 90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated Patients*	3.98	4.00	3.85	3.93	Yes
11. Repeat Unplanned Emergency Visits Within 30 Days for Mental Health Conditions***	18.20%	16.40%	19.73%	17.45%	Yes
12. Repeat Unplanned Emergency Visits Within 30 Days for Substance Abuse Conditions***	28.42%	26.60%	29.20%	29.51%	No
13. Readmission Within 30 Days for Select CMGs***	16.86%	16.00%	17.44%	16.87%	No
14. 90th Percentile Wait Times for CCAC In-Home Services -Application from Community Setting to Service Initiation**	32	30	35	32	No

*Q4 2012/13 **Q3 2012/13 ***Q2 2012/13

LHIN-Initiatives in Support of Ministry Priorities

EXPANDED ROLE FOR CCACS

Over the past year, the North West Community Care Access Centre has continued to expand its role to assess and determine placement into supportive housing and assisted living, adult day programs, complex continuing care and rehabilitation services across the Northwest region. An Implementation Steering Committee monitors the implementation of this enhanced role, identifies issues and concerns, and develops solutions.

PROVINCIAL FALLS PREVENTION PROGRAM

The Provincial Falls Prevention Program was initiated in November 2010 with a goal to improve the quality of life and wellbeing of seniors in Ontario through prevention of falls and fall-related injuries. Phase 1 of the project, co-led by the LHINs and Public Health, brought together health system partners to create a common framework to reduce and lessen the impact of falls. The North West LHIN was a leader in the province with its North West LHIN-Wide Falls Injury Prevention Collaborative.

Phase 2 of the project, approved in September 2012, introduced an early adopter model to spread best practices. The North West LHIN has included indicators in its service accountability agreements with health service providers to sustain the gains achieved in Phase 1 of the regional falls prevention program.

REHABILITATION AND COMPLEX CONTINUING CARE EXPERT PANEL

The North West LHIN conducted a regional study of utilization of complex continuing care and rehab beds across the continuum including community settings, hospitals, transitional and convalescent care settings, and in long-term care. As a result of this study, we have developed a report in preparation for future redesign of the rehab and complex continuing care system. *The goal is* to create an integrated regional rehabilitation model in line with the Health Services Blueprint.

SENIOR FRIENDLY HOSPITALS

For this initiative, the North West LHIN included information in its service accountability agreements, asking all hospitals to use the resources of the provincial toolkit to address delirium and management of functional decline within the hospital environment. One of the North West LHIN's health service providers is piloting the senior-friendly indicators.

EXCELLENT CARE FOR ALL ACT STRATEGIC ROLE TO SUPPORT IMPLEMENTATION

As part of this initiative, the North West LHIN is committed to supporting the implementation of the Excellent Care for All Act by engaging our key stakeholders.

All hospitals in the North West LHIN have submitted quality improvement plans. Though primary care providers are not obligated to share their improvement plans with the North West LHIN, nearly 80% of primary care providers voluntarily did.

Key areas of focus include:

- Commitment to a health system that is patient/client centered
- Active engagement in improving the quality of care Ontarians receive
- Improvement in care effectiveness and value
- Participation across the organization, ranging from patients to the Board

PALLIATIVE CARE*

(see page 20 for North West LHIN results)

BEHAVIOURAL SUPPORTS ONTARIO*

(see page 20 for North West LHIN results)

TRANSITION MANAGEMENT: HOME FIRST

(see page 16 for North West LHIN results)

North West LHIN Operational Performance

The total number of staff at the North West LHIN as of March 31, 2013 was 40 full-time equivalents. The North West LHIN operational budget was $6,465,534 which is less than 1% of the total LHIN-funded health care budget for Northwestern Ontario.

Health Service Providers Working Together in a Time of Crisis

On May 28, 2012, the City of Thunder Bay and two surrounding townships declared a state of emergency due to prolonged and extreme rainfall resulting in substantial flooding, sewer system backup and corresponding public and private housing and infrastructure damages. All three communities were later declared disasters by the Province of Ontario, with more than 2,000 homes in Thunder Bay impacted.

As a result, the North West LHIN activated its emergency response plan, and asked the same of all health service providers within the City of Thunder Bay.

A Health Services Working group was established to respond to the health needs of the flood victims, which included seniors, people living with disabilities and/or chronic conditions and individuals coping with the stresses related to flood damage.

Due to the efforts of this group and other health service providers in the city, 300 people were able to have their health needs assessed, triaged and treated in the community, rather than going to the emergency department for care.

A special thank you to the LHIN-funded health service providers who responded to this crisis:

NorWest Community Health Centre

North West Community Care Access Centre

Canadian Mental Health Association (Thunder Bay)

Thunder Bay Counselling Centre

Thunder Bay District Health Unit

Red Cross

Looking Ahead

Much of the work this past year was guided by the North West LHIN's Health Services Blueprint, launched in March 2012. The Health Services Blueprint is a 10-year plan to reshape, transform, strengthen and sustain the health care system in Northwestern Ontario. It contains 44 recommendations to improve the way the North West LHIN allocates health care resources in order to ensure the best possible care and health outcomes for patients. Taken together, those recommendations point to a system in which providers explore new partnerships and work together to better integrate care and deliver services to patients across the Northwest.

As noted earlier in this document, 2013 was the final year covered by the North West LHIN's second IHSP, and saw the development of the organization's third IHSP. This new IHSP will run from April 1, 2013 to March 31, 2016, and as is the case with the Health Services Blueprint, the focus is on better and more integration. To develop the IHSP III, best practices in other jurisdictions were studied and modelled, and the best research data available was used in drafting the plan. There was also extensive input from health service providers across Northwestern Ontario. Finally, the North West LHIN engaged and consulted with more than 18,000 individuals, groups and organizations over the past three years to inform the IHSP III.

This new IHSP builds on the foundation that was laid by the previous plan, and the accomplishments listed in this document. Over the course of the next three years, efforts will focus on four priority areas identified in the IHSP III to address the unique challenges of delivering health care in the North:

1. Building an Integrated Health System
2. Building an Integrated eHealth Framework
3. Improving Access to Care
4. Enhancing Chronic Disease Prevention and Management

The road to integration is a long one, and we have made real progress over the past year. The North West LHIN is looking ahead to a period of significant change and improvement to the region's health care system. Patient care will remain at the heart of what we do, and because what is best for patients is also best for the system, health care in this region will be even stronger three years from now.

Financial statements of

North West Local Health Integration Network

March 31, 2013

North West Local Health Integration Network

March 31, 2013

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Independent Auditor's Report

To the Members of the Board of Directors of the
North West Local Health Integration Network

We have audited the accompanying financial statements of North West Local Health Integration Network, which comprise the statement of financial position as at March 31, 2013, and the statement of financial activities, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of North West Local Health Integration Network as at March 31, 2013 and the results of its financial activities, change in its net debt and its cash flows for the years then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
May 28, 2013

North West Local Health Integration Network

Statement of financial position
as at March 31, 2013

	2013	2012
	$	$
Financial assets		
Cash	**675,600**	770,616
Due from Ministry of Health and Long Term Care ("MOHLTC") Health Service Provider ("HSP") transfer payments (Note 9)	**6,009,913**	993,674
Accounts receivable	**55,826**	103,835
	6,741,339	1,868,125
Liabilities		
Accounts payable and accrued liabilities	**379,189**	517,592
Due to HSPs (Note 9)	**6,009,913**	993,674
Due to MOHLTC (Note 3)	**340,689**	340,467
Due to the LHIN Shared Services Office (Note 4)	**11,548**	16,392
Deferred capital contributions (Note 5)	**270,854**	301,096
	7,012,193	2,169,221
Net debt	**(270,854)**	(301,096)
Commitments (Note 6)		
Non-financial assets		
Tangible capital assets (Note 7)	**270,854**	301,096
Accumulated surplus	**-**	-

Approved by the Board

L Jay Workenton
Director

Director

North West Local Health Integration Network

Statement of financial activities
year ended March 31, 2013

	Budget (Note 8)	2013 Actual	2012 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSPs transfer payments (Note 9)	**599,727,200**	**626,111,646**	606,341,278
Operations of LHIN	**4,779,592**	**4,724,868**	5,011,567
Aboriginal Community Engagement (Note 11)	**160,000**	**160,000**	160,000
Emergency Department ("ED") LHIN Lead (Note 13)	**75,000**	**75,000**	75,000
Critical Care ("CC") LHIN Lead (Note 16)	**75,000**	**75,000**	75,000
Emergency Room/Alternative Level of Care ("ER/ALC") Performance Lead (Note 14)	**100,000**	**100,000**	100,000
Primary Care ("PC") LHIN Lead (Note 17)	-	**75,000**	43,750
French Language Health Services (Note 15)	**106,000**	**106,000**	106,000
Bahavioural Supports Initiative ("BSO") (Note 18)	-	-	72,000
Diabetes Regional Coordination Centre (Note 19)	-	**436,821**	-
eHealth (Note 12)	-	**580,000**	600,000
Amortization of deferred capital contributions (Note 5)	-	**132,845**	107,629
	605,022,792	**632,577,180**	612,692,224
Funding repayable to the MOHLTC (Note 3)		**(440,689)**	(450,467)
	605,022,792	**632,136,491**	612,241,757
Expenses			
Transfer payments to HSPs (Note 9)	**599,727,200**	**626,111,646**	606,341,278
General and administrative (Note 10)	**4,779,592**	**4,845,042**	4,874,919
Aboriginal Community Engagement (Note 11)	**160,000**	**124,304**	131,173
eHealth (Note 12)	-	**462,808**	556,785
ED LHIN Lead (Note 13)	**75,000**	**74,449**	75,000
CC LHIN Lead (Note 16)	**75,000**	**73,924**	74,528
Emergency Room/Alternative Level of Care ("ER/ALC") Performance Lead (Note 14)	**100,000**	**92,485**	8,827
Primary Care ("PC") LHIN Lead (Note 17)	-	**73,449**	13,337
French Language Health Services (Note 15)	**106,000**	**106,000**	102,938
BSO (Note 18)	-	-	62,972
Diabetes Regional Coordination Centre (Note 19)	-	**172,384**	-
	605,022,792	**632,136,491**	612,241,757
Annual surplus and accumulated surplus, end of year	-	-	-

North West Local Health Integration Network

Statement of change in net debt
year ended March 31, 2013

	2013	2012
	$	$
Annual surplus	-	-
Decrease in prepaid expenses, net	-	6,012
Acquisition of tangible capital assets	(102,603)	(19,625)
Amortization of tangible capital assets	132,845	107,629
Decrease in net debt	30,242	94,016
Net debt, beginning of year	(301,096)	(395,112)
Net debt, end of year	(270,854)	(301,096)

North West Local Health Integration Network

Statement of cash flows
year ended March 31, 2013

	2013	2012
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of tangible capital assets	**132,845**	107,629
Amortization of deferred capital contributions (Note 5)	**(132,845)**	(107,629)
Changes in non-cash operating items		
(Increase) Decrease in due from MOHLTC - HSPs transfer payments	**(5,016,239)**	4,155,631
Decrease (increase) in accounts receivable	**48,009**	(1,742)
Decrease in accounts payable and accrued liabilities	**(138,403)**	(54,263)
Increase (decrease) in due to HSPs	**5,016,239**	(4,155,631)
Increase in due to MOHLTC	**222**	137,355
(Decrease) increase in due to LHIN Shared Services Office	**(4,844)**	14,608
Decrease in prepaid expenses	-	6,012
	(95,016)	101,970
Capital transaction		
Acquisition of tangible capital assets	**(102,603)**	(19,625)
Financing transaction		
Increase in deferred capital contributions (Note 5)	**102,603**	19,625
Net (decrease) increase in cash	**(95,016)**	101,970
Cash, beginning of year	**770,616**	668,646
Cash, end of year	**675,600**	770,616

North West Local Health Integration Network

Notes to the financial statements
March 31, 2013

1. Description of business

The North West Local Health Integration Network was incorporated by Letters Patent on June 16, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the North West Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Districts of Thunder Bay, Rainy River and most of Kenora. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with Ministry-LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC") and provides the framework for the LHIN accountabilities and activities. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed Health Service Providers ("HSP") in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2013.

The LHIN statements do not include any MOHLTC managed programs.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets and impairments in the value of assets.

North West Local Health Integration Network

Notes to the financial statements
March 31, 2013

2. **Significant accounting policies (continued)**

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Office furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Web development	3 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year.

Segmented information

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently disclose information for all appropriate segments and therefore no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

North West Local Health Integration Network

Notes to the financial statements
March 31, 2013

2. **Significant accounting policies (continued)**

Adoption of new accounting standards

As at April 1, 2012, the LHIN adopted Public Sector Accounting Handbook *Section PS 1201, "Financial Statement Presentation"*, Section PS 2601 *"Foreign Currency Translation"*, PS 3410 "*Government Transfers*" and Section PS 3450, *"Financial Instruments"*. There was no impact of the adoption of these new standards on the financial statements.

3. **Funding repayable to the MOHLTC**

In accordance with the MLPA, the LHIN is required to be in a balanced position at year-end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

In accordance with the TPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to MOHLTC.

The amount repayable to the MOHLTC related to the current year activities is made up of the following components:

			2013	2012
	Funding	Eligible expenses	Funding excess	Funding excess
	$	$	$	$
Transfer payments to HSPs	626,111,646	626,111,646	-	-
LHIN operations	4,857,713	4,845,043	12,670	244,277
Aboriginal Community Engagement	160,000	124,304	35,696	28,827
E-Health	580,000	462,808	117,192	43,215
ED LHIN Lead	75,000	74,449	551	-
Critical Care ("CC") LHIN Lead	75,000	73,923	1,077	472
ER/ALC Performance Lead	100,000	92,485	7,515	91,173
PC LHIN Lead	75,000	73,449	1,551	30,413
French Language Health Services	106,000	106,000	-	3,062
BSO Strategy	-	-	-	9,028
Diabetes Education	436,821	172,384	264,437	-
	632,577,180	632,136,491	440,689	450,467

The continuity of the amount due to the MOHLTC at March 31 is as follows:

	2013	2012
	$	$
Due to MOHLTC, beginning of year	340,467	203,113
Funding repaid to MOHLTC	(340,467)	(203,113)
Funding repayable to the MOHLTC related to current year activities	440,689	450,467
In year surplus recovered by MOHLTC	(100,000)	(110,000)
Due to MOHLTC, end of year	340,689	340,467

North West Local Health Integration Network

Notes to the financial statements
March 31, 2013

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at year end is recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all LHINs.

5. Deferred capital contributions

	2013	2012
	$	$
Balance, beginning of year	**301,096**	389,100
Capital contributions received during the year	**102,603**	19,625
Amortization for the year	**(132,845)**	(107,629)
Balance, end of year	**270,854**	301,096

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment extending to 2016. Lease renewals are likely. Minimum lease payments due in each of the next five years are as follows:

	$
2014	314,920
2015	306,321
2016	85,640
2017	12,061
2018	1,732
	720,674

The LHIN also has funding commitments to HSPs associated with accountability agreements. Minimum commitments to HSPs related to the next five years, based on the current accountability agreements, are as follows:

	$
2014	398,345,510
2015	67,174,056
2016	67,174,056
2017	-
2018	-

The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

North West Local Health Integration Network

Notes to the financial statements
March 31, 2013

7. Tangible capital assets

	Cost	Accumulated amortization	2013 Net book value	2012 Net book value
	$	$	$	$
Office furniture and fixtures	368,487	291,603	76,884	51,233
Computer equipment	139,487	115,612	23,875	12,738
Leasehold improvements	699,643	529,548	170,095	237,125
Web development	7,251	7,251	-	-
	1,214,868	944,014	270,854	301,096

8. Budget figures

The budget was approved by the Government of Ontario. The budget figures reported in the statement of financial activities reflect the initial budget. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles. During the year, the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $626,111,646 is derived as follows:

	$
Initial HSP funding budget	599,727,200
Adjustment due to announcements made during the year	26,384,446
Final HSP funding budget	626,111,646

The final LHIN budget, excluding the HSP funding, of $6,332,689 is derived as follows:

	$
Initial budget	5,295,592
Additional funding received during the year	
E-Health	580,000
Primary Care Lead	75,000
Diabetes Education	484,700
Amount treated as capital contributions made during the year	(102,603)
Final budget	6,332,689

North West Local Health Integration Network

Notes to the financial statements
March 31, 2013

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $626,111,646 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

	2013	2012
	$	$
Operation of hospitals	**430,592,371**	420,030,397
Health Infrastructure Renewal Fund	**-**	-
Grants to compensate for municipal taxation - public hospitals	**105,375**	105,375
Long term care homes	**68,994,752**	68,511,429
Community care access centres	**49,289,693**	42,902,747
Community support services	**14,047,377**	14,070,995
Acquired brain injury	**1,817,347**	1,817,347
Assisted living services in supportive housing	**8,502,520**	7,290,866
Community health centres	**8,580,270**	8,269,886
Community mental health program	**30,527,514**	30,733,101
Addictions program	**13,654,427**	12,609,135
	626,111,646	606,341,278

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2013, an amount of $6,009,913 (2012 - $993,674) was receivable from the MOHLTC, and $6,009,913 (2012 - $993,674) was payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of financial activities and are included in the table above.

10. General and administrative expenses

The statement of financial activities presents expenses by function. The following classifies general and administrative expenses by object:

	2013	2012
	$	$
Salaries and benefits	**3,398,182**	2,996,101
Occupancy	**240,174**	237,024
Amortization	**132,845**	107,629
Equipment and maintenance	**41,926**	45,325
Shared services	**361,520**	475,025
Public relations and community forums	**27,727**	10,526
Professional fees	**14,800**	14,500
Travel	**110,807**	150,039
Staff development and recruitment	**106,810**	122,724
Consulting services	**27,352**	381,910
LHIN collaborative	**47,500**	26,971
Supplies, printing and office	**98,501**	82,018
Other board member per diems	**58,336**	63,428
Board chair per diems	**25,200**	23,945
Other governance and travel costs	**86,943**	68,002
Mail, courier and telecommunications	**66,419**	69,752
	4,845,042	4,874,919

North West Local Health Integration Network

Notes to the financial statements
March 31, 2013

11. Aboriginal Community Engagement

The Ministry of Health and Long-Term Care provided $160,000 (2012 - $160,000) in additional base operational funding which was annualized for the purposes of engaging the Aboriginal population and organizations in the North West LHIN. During 2013, $124,304 (2012 - $131,173) of expenses were incurred.

12. eHealth Ontario

The Ministry of Health and Long-Term Care provided $580,000 (2012 - $600,000) to the LHIN. The funds were used to cover the operational and project costs associated with the LHIN Project Management Office infrastructure and eHealth Ontario activities. During the year, $462,808 (2012 - $556,785) of expenses were incurred.

13. Emergency Department LHIN Lead

The Ministry of Health and Long-Term Care provided $75,000 (2012 - $75,000) in one-time funding to support the compensation of the North West LHIN Emergency Department (ED) LHIN Lead. During the year, $74,449 of expenses were incurred (2012 - $75,000).

14. ER/ALC Performance Lead

The Ministry of Health and Long-Term Care provided one-time funding in the amount of $100,000 (2012 - $100,000) to support the compensation of the LHIN ER/ALC Performance Lead in 2012/13. During the year, $92,485 (2012 - $8,827) of expenses were incurred.

15. French Language Health Services

The Ministry of Health and Long-Term Care approved one-time funding of $106,000 (2012 - $106,000) to support the LHIN in its French Language Services activities. During the year, $106,000 (2012 - $102,938) of expenses were incurred.

16. Critical Care Lead

The Ministry of Health and Long-Term Care provided one-time funding in the amount of $75,000 (2012 - $75,000) to support the compensation of the LHIN Critical Care Lead in 2012/13. During the year, $73,923 (2012 - $74,528) of expenses were incurred.

17. Primary Care Lead

The Ministry of Health and Long-Term Care provided one-time funding in the amount of $75,000 (2012 - $43,750) to support the compensation of the LHIN Primary Care Lead in 2012/13. During the year, $73,449 (2012 - $13,337) of expenses were incurred.

18. Behavioural Supports Initiative (BSO)

The Ministry of Health and Long-Term Care provided one-time funding in the amount of $nil (2012 - $72,000) to support the compensation of the LHIN BSO Initiative in 2012/13. During the year, $nil (2012 - $62,972) of expenses were incurred.

North West Local Health Integration Network

Notes to the financial statements
March 31, 2013

19. Diabetes Regional Coordination Centre

The Ministry of Health and Long-Term Care provided one-time funding in the amount of $484,700 (2012 - $nil) to support the compensation of the LHIN Diabetes Regional Coordination Centre in 2012/13. During the year, $220,263 (2012 - $nil) of expenses were incurred which includes $47,879 in capital purchases (2012 - $nil). Expenses incurred include the following:

	2013	2012
	$	$
Salaries & Benefits	113,026	-
Operating expenses	59,358	-
One-time expenses	47,879	-
	220,263	-

20. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 37 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2013 was $321,703 (2012 - $286,504) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation was completed for the plan in December 31, 2012. At that time, the plan was fully funded.

21. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s. 28 of the *Financial Administration Act*.

22. Comparative figures

Certain comparative figures have been reclassified to conform to the current year presentation.

North West Local Health Integration Network

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